

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		8 4 1 3 6 9 2 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Vernon Wilson Ayres		2a. DATE OF DEATH MONTH DAY YEAR May 23, 1984	
3. SEX Male		2b. HOUR 1:45a.m.	
4. RACE Caucasian		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
5. DATE OF BIRTH MONTH DAY YEAR Jan. 26, 1903		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH La Plata		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12b. KIND OF BUSINESS OR INDUSTRY Saw Mill	
13a. STATE Maryland		13b. STREET ADDRESS 20607	
13c. CITY OR TOWN Accokeek		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Unavailable Ayres		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unavailable	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-01-1056	
17. INFORMANT (Son) Curtis V. Ayres, Same as Line 13		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) <u>metastatic cancer of liver</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer Pancreas</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>August 19 81</u> , to <u>5/22/19 84</u> , that (I) (we) lost saw the deceased alive on <u>5/22/19 84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>N Bhaduri</u>		22c. DATE SIGNED 5/23/1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nirendra Bhaduri, M.D.		22e. ADDRESS Waldorf, Md. 20601	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-25-1984	
23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gdns.		23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, Md.	
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Md.		25. DATE REC'D. BY REGISTRAR MAY 25 1984	
25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			



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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PARTS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 6 9 3	
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) <b>Kate Berry</b>										2b. HOUR 24 6 PM	
2. SEX <b>F</b> 4. RACE <b>B</b> 5. DATE OF BIRTH 1-5-10 6. AGE (IN YEARS) 74 YRS.										2c. DATE PRONOUNCED DEAD 5 3 19 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b> 7b. CITIZEN OF WHAT COUNTRY? <b>United States</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b>	
10. CITY OR TOWN OF DEATH <b>LaPlata</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physician Memorial Hospital</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Gov. Worker</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>											
13a. STATE <b>Maryland</b> 13b. COUNTY <b>Charles</b> 13c. CITY OR TOWN <b>Nanjemoy</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>Route 1 Box 1 20662</b>											
14. FATHER'S NAME FIRST <b>Joseph</b> MIDDLE <b>Marbury</b> LAST <b>Kate</b> 15. MOTHER'S MAIDEN NAME FIRST <b>Kate</b> MIDDLE <b>Lawson</b> LAST <b>Lawson</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> 16b. SOCIAL SECURITY NO. <b>215-14-0165 D</b> 17. INFORMANT ADDRESS <b>Veronica Cobey Nanjemoy, Md. 20662</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4292 ASCVD</b> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4292</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>H. Mahan</b> TITLE (SPECIFY) <b>Charles C</b> M.D. MEDICAL EXAMINER DATE SIGNED <b>3 May 84</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>H. Mahan - Hft MD</b> ADDRESS <b>SP# Box 1020, La Plata, Md 20646</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>May 8 '84</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Baptist</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Grayton Charles Md.</b>											
24. FUNERAL DIRECTOR <b>Thornton Funeral Home</b> ADDRESS <b>Pomomkey, Md.</b> 25a. DATE REC'D. BY REGISTRAR <b>MAY 8 1984</b> 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>											



Handwritten text at the bottom left corner, possibly a signature or date.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 6 9 4			
1. DECEASED NAME (TYPE OR PRINT) <u>William S. Bowling</u>						2a. DATE KNOWN OF DEATH ESTIMATED <u>5 3 1984</u>		2b. HOUR <u>12:00 PM</u>		2c. DATE PRONOUNCED DEAD <u>5 4 1984</u>		2d. HOUR <u>10:19 PM</u>	
3. SEX <u>M</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>3</u> DAY <u>28</u> YEAR <u>00</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>76</u> YRS.		7. IF UNDER 1 YR. MONTHS <u>0</u> DAYS <u>0</u>		7. IF UNDER 24 HRS. HOURS <u>0</u> MIN. <u>0</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Washington, D.C.</u>				7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>				9. BALTIMORE CITY OR COUNTY OF DEATH <u>Charles</u>				MD.	
10. CITY OR TOWN OF DEATH <u>La Plata</u>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>La Plata Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Construction</u>				12b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	
13a. STATE <u>Maryland</u>				13b. COUNTY <u>Charles</u>		13c. CITY OR TOWN <u>LaPlata</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>Rt. 6 Box 1014 20646</u>			
14. FATHER'S NAME FIRST <u>Joseph</u> MIDDLE <u>B.</u> LAST <u>Bowling</u>						15. MOTHER'S MAIDEN NAME FIRST <u>Mary</u> MIDDLE <u>L.</u> LAST <u>Dyer</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO. <u>217 32 0649</u>		17. INFORMANT ADDRESS <u>17714 N.H. Ave. Ashton, Md</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <u>4960</u> IMMEDIATE CAUSE (a) <u>Chronic obstructive Pulmonary Disease</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>H. M. Mahon. Haft</u>				TITLE (SPECIFY) <u>Charles</u>				MEDICAL EXAMINER				DATE SIGNED <u>5 May 84</u>	
EXAMINER'S NAME (TYPE OR PRINT) <u>H. M. Mahon. Haft, MD</u>				ADDRESS <u>SR#1 Box 1020, LaPlata, MD</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>5/9/84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>				23d. LOCATION CITY OR TOWN <u>Beallsville</u> COUNTY <u></u> STATE <u>Md.</u>			
24. FUNERAL DIRECTOR NAME <u>Hines/Rinaldi Funeral Home</u> ADDRESS <u>11800 N.H. Ave., Silver Spring, Md.</u>						25a. DATE REC'D. BY REGISTRAR <u>MAY 8 1984</u>		25b. REGISTRAR'S SIGNATURE <u>Jana Davidson-Randall</u>					

13-10-1971

30-10-1971

10-11-1971

1

10-11-1971

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM# 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO. 1 3 6 9 6

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna Melinda Depew			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 5 20 1984 MONTH DAY YEAR		2b. HOUR 6 00 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4 17 71	6. AGE (IN YEARS) (LAST BIRTHDAY) 13 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 5 20 1984 MONTH DAY YEAR
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7a. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Charles	13c. CITY OR TOWN Faulkner	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Ray Clifton DePew, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Elizabeth Lawrence		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS Clara E. DePew same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9109 IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>+</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>+</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Drowned in farm pond	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Farm		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Timberneck farm, Faulkner, Charles Md	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE H M Mahan Haft		TITLE (SPECIFY) M.D. Charles Co		MEDICAL EXAMINER DATE SIGNED 21 May 84	
EXAMINER'S NAME (TYPE OR PRINT) H M Mahan Haft M		ADDRESS 52#1 Box 1020 La Plata Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-24-84		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cem.	
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc.		ADDRESS La Plata, Md.		25a. DATE REC'D. BY REGISTRAR MAY 25 1984	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		82		13695		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR A M	
Ollie		May		Dennison		May 25, 1984		2:25		A	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		Cau.		Aug. 6, 1902		81		YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		U.S.A.				Charles MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
La Plata		Physicians Memorial Hospital									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Homemaker		Own Home									
13a. STREET ADDRESS										13b. INSIDE CITY LIMITS?	
Bumpy Oak Road										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Rt. #2 Box 2272, 20646											
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
James		Brooks		Fanny		E.		Cambell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		213-74-2123		Lorena Wright		Rt. #2 Box 2271 La Plata, Md. 20646					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
4360 IMMEDIATE CAUSE (a) Cardio pulmonary arrest											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Cerebrovascular Accident											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
Coronary Heart Disease.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5-10-19-84, to 5-25-19-84, that (I) (we) last saw the deceased alive on 5-24-19-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
G. Rath				5-25-84							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Dr. G. Shenkar Rath, M.D.		Charles Professional Building				Waldorf, Maryland 20601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		5-28-84		Trinity Mem. Gardens		Waldorf, Charles, Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Huntt Funeral Home, Maryland				MAY 28 1984		J. Davidson					

MEDICAL CERTIFICATION



James	Brooklyn	E. L. Campbell	Rt. 1 Box 2271	217-26-211	James Wright La Plante, Rt. 20646
Harvard	Charles La Plante	X	Rt. 2 Box 2272, 20646		Bunny Oak Road
Virginia	U.S.A.	X	Charles		Division Memorial Hospital
Female	Can.		Aug. 6, 1903		21
Oliver	May	Jan 1904	Nov 25, 1984	2:25	

Hunt Funeral Home, Albert, Maryland  
 2-2646 Trinity Lutheran, Albert, Charles, Md.  
 Dr. D. Shepherd, N.D.  
 2-26-84  
 2-26-84



FOR STATE  
HEALTH DEPT.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4 1 3 6 9 7

1. DECEASED-NAME (Type or Print) <b>Harvey Duncan DuBois</b>			20. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 5 20 1984			2b. HOUR 12:30 A.M.		
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>8-6-25</b>	6. AGE (In years last birthday) <b>58</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <b>5</b> Day <b>20</b> Year <b>1984</b>		2d. HOUR <b>8:00 A.M.</b>
7a. BIRTHPLACE (State or foreign country) <b>Vermont</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Charles</b> Md.		
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Physicians Memorial</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Military</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before) <b>Maryland</b>			13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Indian Head</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER <b>10 Davis Drive, 20640</b>			14. FATHER'S NAME First <b>Arthur</b> Middle <b>DuBois</b> Last <b>Ethel</b>			15. MOTHER'S MAIDEN NAME First <b>Keith</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>1943-1974 008-12-4558</b>		17. INFORMANT <b>Flushing, New York 11367</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia -</b>								
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cancer, ASCVD</b>								
DUE TO, OR AS A CONSEQUENCE OF (c) <b>fever</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>H. M. Mahan</b>			M.D.			22b. DATE SIGNED <b>20 May 84</b>		
EXAMINER'S NAME (Type) <b>H. M. Mahan</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-23-1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maryland Veteran's</b>		23d. LOCATION (City or Town) (County) (State) <b>Cheltenham, P.G., Md.</b>		
24. FUNERAL DIRECTOR <b>Huntt Funeral Home, Waldorf, Maryland</b>				25a. REC'D BY REGISTRAR <b>MAY 24 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES  
DEPARTMENT OF HEALTH



OFFICE OF THE  
DIRECTOR  
OF THE  
BUREAU OF  
HYGIENE  
WASHINGTON, D. C.

ASSISTANT SECRETARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified by the funeral director.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>George Preston Dyson</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>5-23-84</i>		2b. HOUR MIN. <i>5 30</i> <sup>A</sup> <sub>M</sub>		
3. SEX <i>male</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8 22 1876</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>87</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Charles Co</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Charles County</i> MD.			
10. CITY OR TOWN OF DEATH <i>La Plata</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Meridian Nursing Center</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Agriculture.</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>Charles</i>		13c. CITY OR TOWN <i>Charlotte Hall</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>Rt. 1, Box 427, 20622</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Wm Walter Dyson</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Katherine Moran</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i>					16b. SOCIAL SECURITY NO. <i>214-36-3546</i>		17. INFORMANT (wife) ADDRESS <i>Minnie C. Dyson, Same as line 13</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Brain Syndrome</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Aspiration, Genito urinary Tract Infection - Debridement</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Aspiration, Genito urinary Tract Infection - Debridement</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <i>5-12</i> , 19 <i>84</i> , to <i>5-23</i> , 19 <i>84</i> , that (1) (we) last saw the deceased alive on <i>5-12</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Henry J. Burke MD</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>5-23-84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Henry J. Burke, Md.</i>					22e. ADDRESS <i>La Plata, Maryland</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5-26-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Trinity Episc. Church</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Newport, Charles, Md.</i>		
24. FUNERAL DIRECTOR NAME ADDRESS <i>Hunt Funeral Home, Waldorf, Md.</i>					25a. DATE REC'D. BY REGISTRAR <i>MAY 25 1984</i>				
					25b. REGISTRAR'S SIGNATURE <i>John Davidson-Rendell</i>				

BP \_\_\_\_\_



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13699					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William J Ford										2a. DATE KNOWN OF DEATH ESTIMATED 5 18 1984		2b. HOUR 10:09 AM			
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 12 31 20		6. AGE (IN YEARS) LAST BIRTHDAY 55 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 5 19 1984		2d. HOUR 12:01 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD			
10. CITY OR TOWN OF DEATH La Plata				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physician Mem. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farming				12b. KIND OF BUSINESS OR INDUSTRY Labor			
13a. STATE Maryland				13b. COUNTY Charles		13c. CITY OR TOWN Bryantown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rt. 5 Box 9, 20617					
14. FATHER'S NAME FIRST MIDDLE LAST Moses Ford						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Gross									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO. 216-30-4818		17. INFORMANT 4559 ADDRESS Dallas Place				17. INFORMANT 4559 ADDRESS Dallas Place			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8902 Smoke inhalation, thermal injury DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minute					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:00 P.M. 18 May 1984				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) House fire							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Box 9 Bryantown Md				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Box 9 Bryantown Charles Md							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE H.M. Mahan-Haft				TITLE (SPECIFY) Charles G.				MEDICAL EXAMINER				DATE SIGNED 10 May 84			
EXAMINER'S NAME (TYPE OR PRINT) H.M. Mahan-Haft MD				ADDRESS SR#1 Box 1020 La Plata, MD 20646											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-22-84		23c. NAME OF CEMETERY OR CREMATORY St. Peters Ch				23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf Charles Md					
24. FUNERAL DIRECTOR NAME Martell Adams				ADDRESS Aguasco, Md.				25a. DATE REC'D. BY REGISTRAR MAY 25 1984				25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 3 7 0 0  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>William Harold Gough</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>05 05 84</b>		2b. HOUR <b>4:48AM</b>		
3. SEX <b>Male</b>		4. RACE <b>Gau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 18, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.	
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Waldorf</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Gough</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Virginia Robey</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>219-12-2845 Leatha I. Gough same as 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>5751</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute myocardial infarction.</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH <b>a few hours</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <b>5/3/84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cholecystitis, cholelithiasis</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19 84</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OF PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5/2 19 84</b> to <b>5/5 19 84</b> , that (I) (we) last saw the deceased alive on <b>5/5 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23a. SIGNATURE <b>Dr. A. Monteiro, MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED <b>5/5/84</b>	
23b. PHYSICIAN'S NAME (TYPE OR PRINT)		22a. ADDRESS <b>La Plata, MD 20646</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-8-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Vet. Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cheltenham, P.G. Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hunt Funeral Home, Waldorf, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 8 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

During the past few years, the Government has been making a study of the problem of the control of the arms trade. It has been found that the arms trade is a very important factor in the maintenance of international peace and security. The Government has been working to develop a system of control which will be effective in preventing the arms trade from becoming a source of international conflict.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		84 REG. NO. 13701								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter Howard Haas					2a. DATE OF DEATH MONTH DAY YEAR 05 13 84			2b. HOUR 12:12 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 25, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.				
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Sales Rep.		
13a. STATE Md.					13b. COUNTY Charles		13c. CITY OR TOWN La Plata		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Haas					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Knopp					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-14-1494		17. INFORMANT ADDRESS Jarwood Clinic J. Parran Jarboe La Plata, Md. 20646						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>5/12/84</u> to <u>5/13/84</u> , that (I) (we) lost saw the deceased alive on <u>5/13/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Dr. S. Nagula MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/13/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. Nagula, MD				22e. ADDRESS Waldorf, MD 20601						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5-14-84		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Maryland				
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc. La Plata, Md.				25a. DATE RECEIVED BY REGISTRAR MAY 18 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall				

MEDICAL CERTIFICATION

Archert Funeral Home, Inc. La Plata, Md.

Cremation 2-14-40 The Crematory

Clinton S.S. Maryland



x

George Hoss Anna  
870-1-7484 J. Warren Jarboe La Plata, Md. 20646  
Jarboe Clinic  
Inopp

Mr. Charles La Plata XX Howard Johnsons Hotel

8ip: 20646

Self employed Sales Rep.

Pinnesco U.S.A. XX  
White Nov. 25, 1900 93

after Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

8413703

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William O Helwig			2a. DATE OF DEATH MONTH DAY YEAR May 9, 1984		2b. HOUR 3:50 P <sub>M</sub>
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 11, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Finksburg, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH La Plata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Laborer	
13a. STATE Md.		13b. COUNTY Charles	13c. CITY OR TOWN Marbury	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Philip O. Helwig		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Murray			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-32-5390		17. INFORMANT ADDRESS Mrs. William Grinder Marbury, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 10 days Few years.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Old Myocardial Infarction, Malnutrition, Renal Disease, Lump, right neck</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>April 30, 1984</b> to <b>May 9, 1984</b> , that (I) (we) lost saw the deceased alive on <b>May 9, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Aurelio C. Delapaz, M.D.</b>				22c. DATE SIGNED 5-9-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aurelio Delapaz				22e. ADDRESS La Plata, Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 12, 84		23c. NAME OF CEMETERY OR CREMATORY Finksburg Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg, Md.		24. FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home Reisterstown, Md.			
25a. DATE REC'D. BY REGISTRAR MAY 14 1984				25b. REGISTRAR'S SIGNATURE	

RECEIVED  
JAN 10 1964



Handwritten notes and a table at the top of the page. The table has several columns and rows of data, though the text is mostly illegible due to fading and bleed-through.

Handwritten notes in the middle section, including a prominent heading that appears to be "CREATING HISTORY".

Handwritten notes and a table at the bottom of the page. The table contains several rows of data, with some entries clearly visible like "1000" and "10000".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M.1/81  
(VRA 15, 4)FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 1 3 7 0 2  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Charlotte Leondine Hawthorne</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>May 18, 1984</b>		2b. HOUR <b>10:06<sup>A</sup></b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>August 11, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Connecticut</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. of A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles County, MD.</b>		
10. CITY OR TOWN OF DEATH <b>La Plata</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Charles</b>	13c. CITY OR TOWN <b>La Plata</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>506 Washington Ave. 20646</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Fredrick Leonard Hayes</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Johanna Leondine Johansson</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>1</b>		17. INFORMANT ADDRESS <b>2806 Legion Ave. S.L. Hawthorne-Son, Durham, N.C. 27707</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute reperfusing Collapse, massive</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral vascular accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertensive Cardiovascular disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 min</b> <b>4 day</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>NIDDM Type II lean, required insulin.</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>06/16</b> , 19 <b>67</b> , to <b>05/18</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>05/18</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE <b>Wooddy</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>05/18/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arthur O. Wooddy, M. D.</b>		22e. ADDRESS <b>Box 430 La Plata, Maryland 20646</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>05/20/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee Crematory</b>	
23d. LOCATION CITY OR TOWN <b>Clinton</b>		COUNTY <b>P.G.</b>		STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Arehart Funeral Home, Inc., La Plata, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>MAY 28 1984</b>		
25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randell</b>					

BP



May 11, 1900 10:00  
Washington  
Examination  
Charles  
Connecticut  
U. S. of A.  
8  
Charles County  
to State  
Anselmin Memorial Hospital  
to State  
Maryland  
Charles to State  
200 Washington Ave. 20016  
Fredrick Leonard Hayes  
Johanna  
Washington  
Johannessen  
20016 Ave.  
S. S. Washington-Durham, W.C. 20017

Robert Funeral Home, Inc., to State, W.C.  
MAY 28 1904  
Examination of W.C. to State, W.C.  
Clinton  
P.S. W.C.  
Arthur O. Goddard, N. E.  
Box 100 to State, Maryland 20016



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

741  
1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 REG. NO. 13704

1. DECEASED NAME (TYPE OR PRINT) <b>THOMAS VINCENT HIGGINS, JR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5/21/84 May 21, 1984</b>		2b. HOUR <b>8:40 A</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>07 10 46</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>37</b> YRS.		7. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4609 Harwich Drive</b>		
12. CITY OR TOWN OF DEATH <b>Waldorf</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4609 Harwich Drive</b>		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Comp. Sys. Analyst</b>		
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE <b>Maryland</b>		15b. CITY OR TOWN <b>Charles</b>		15c. STREET ADDRESS / ZIP CODE <b>4609 Harwich Drive, 20601</b>		
16. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Vincent Higgins, Sr.</b>		17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rebecca Martin</b>		18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes 1964-1967</b>		
19. SOCIAL SECURITY NO. <b>577-62-8200</b>		20. INFORMANT <b>Karen Higgins, Same as Line 13</b>		21. ADDRESS		
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastasis to lung; Spinal Cord and liver</b> <b>1725</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Melanoma of back</b> DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b. PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from <b>9/13/1982</b> to <b>5/21/1984</b> , that (I) (we) last saw the deceased alive on <b>(March) 3/14/1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22a. SIGNATURE <b>N. Bhaduri</b>		DEGREE <b>MD.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>May 21, 1984</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Niren N. Bhaduri</b>		22e. ADDRESS <b>Charles Professional Ctr. Waldorf, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-24-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Mem. Gdns.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waldorf, Charles, Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Huntt Funeral Home, Waldorf, Md.</b>				
25a. DATE REC'D. BY REGISTRAR <b>MAY 23 1984</b>		25b. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>				

BP

1:40

WILLIAM VINCENT

Lawson

Lawson

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FOR STATE  
HEALTH DEPT.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4 1 3 7 0 5

1. DECEASED-NAME (Type or Print)			First <b>Irene</b>			Middle <b>Marie</b>			Last <b>Jones</b>			2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year 19 <b>84</b> <b>11</b> <b>PM</b>			2b. HOUR		
3. SEX <b>F</b>		4. RACE <b>B</b>		5. DATE OF BIRTH <b>9-3-1911</b>		6. AGE (In years last birthday) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month <b>5</b> Day <b>13</b> Year <b>1984</b> <b>1:46 PM</b>			2d. HOUR		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Charles County</b> Md.					
10. CITY OR TOWN OF DEATH <b>La Plata</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Physician Mem. Custodian</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>U.S. Gov't</b>				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>				13b. COUNTY <b>Charles</b>				13c. CITY OR TOWN <b>Brandywine</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Rt. 1 Box 240 AA, 20613</b>					
14. FATHER'S NAME First Middle Last <b>Unknown</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>Unknown</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>225-05-0757A</b>		17. INFORMANT <b>Matilda Duckett</b>				ADDRESS <b>SAA</b>							
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4292 ASCVD</b> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquest <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <b>H. M. Mahon-Haft</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>13 May 84</b>									
EXAMINER'S NAME (Type) <b>H. M. Mahon-Haft, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) <b>SR#1 Box 1020, G.P. Pkty, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-17-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Bethel A.M.E</b>				23d. LOCATION (City or Town) (County) (State) <b>Brandywine P.G MD</b>									
24. FUNERAL DIRECTOR ADDRESS <b>Martell Adams Aquasco Maryland 20608</b>				25a. RECEIVED BY REGISTRAR DATE <b>MAY 25 1984</b>				25b. REGISTRAR'S SIGNATURE <b>Ma Davidson-Randall</b>									

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, 3, and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1000. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR DATE  
IN THE DEPT.



MINISTRE DU COMMERCE ET DE L'INDUSTRIE

1952-12-27



CHICAGO

1952

1952

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

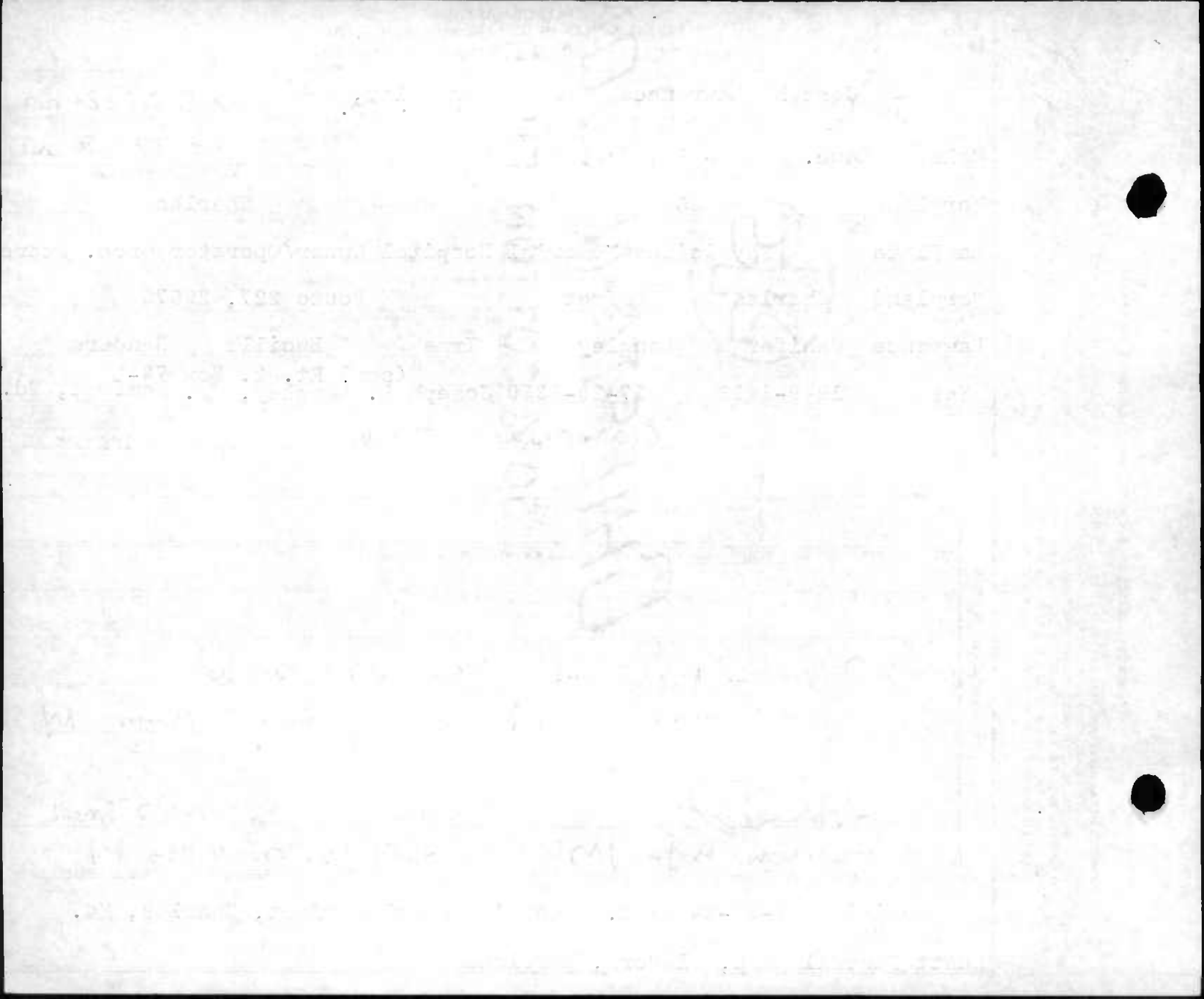
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	3706				
1- FOR STATE REGISTRAR										20. DATE KNOWN OF DEATH		21. MONTH DAY YEAR		22. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marcia Kim Kessler										20. DATE KNOWN OF DEATH		21. MONTH DAY YEAR 5-3 19 84		22. HOUR 5:30 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 09 58		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 25 YRS.		IF UNDER 1 YR.		IF UNDER 24 HRS.		23. DATE PRONOUNCED DEAD		24. MONTH DAY YEAR 5-3 19 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Charles County, MD.			
10. CITY OR TOWN OF DEATH La Plata				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physician's Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver				12b. KIND OF BUSINESS OR INDUSTRY Freight Co.			
13a. STATE PA				13b. COUNTY York				13c. CITY OR TOWN Thomasville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Maurice C. Kessler, Jr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice E. Strouse				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 183-50-7613			
17. INFORMANT				ADDRESS M.C. Kessler, Jr. RD#9, York, PA 17402											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8160 IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR:MIN. MONTH DAY YEAR 4:06 P.M. 5-3 19 84				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of tractor trailer lost control and overturned							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road				21f. LOCATION CITY OR TOWN COUNTY STATE Rt. 301/5, Waldorf, Charles Co., Maryland							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Dennis F. Smyth, M.D.				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 5-4-84			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 5/05/84				23c. NAME OF CEMETERY OR CREMATORY York Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Columbia Lancaster PA			
24. FUNERAL DIRECTOR NAME ADDRESS J.J. Hartenstein, 24 2nd st., New Freedom PA 17349															

2010-2011  
2011-2012  
2012-2013

3222

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3707					
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph Lawrence Langley, Sr.										MONTH DAY YEAR 5 27 1984		0002 M			
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 3-18-1932		6. AGE (IN YEARS) 52 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 27 1984		2d. HOUR 0002 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.			
10. CITY OR TOWN OF DEATH La Plata				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner/Operator				12b. KIND OF BUSINESS OR INDUSTRY Groc. Store			
13a. STATE Maryland				13b. COUNTY Charles		13c. CITY OR TOWN Pomfret		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 227, 20675					
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Jenifer Langley						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irma Lucille Sanders									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 1949-1953		17. INFORMANT (son) Rt. 2, Box 74-L Joseph L. Langley, Jr. Pomfret, Md.				ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8199 IMMEDIATE CAUSE (a) Cranio-cervical trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:15 PM 5-26-84				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Motor Vehicle Accident							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Marshall's Corner Road Charles MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE HMM				TITLE (SPECIFY) M.D. Charles G				MEDICAL EXAMINER DATE SIGNED 27 May 84							
EXAMINER'S NAME (TYPE OR PRINT) H M Mahan, Haft MD				ADDRESS 5041 Rea laro G Plata Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-30-84		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Church				23d. LOCATION CITY OR TOWN COUNTY STATE Pomfret, Charles, Md.					
24. FUNERAL DIRECTOR NAME Hunt Funeral Home				ADDRESS Waldorf, Maryland				25a. DATE REC'D. BY REGISTRAR MAY 31 1984		25b. REGISTRAR'S SIGNATURE					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8413708

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
ROBERT Elwood MILLER Sr.		MAY 18 1984		9:15 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
MALE	WHITE	MONTH 8 DAY 20 YEAR 1913	70	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Penn	U.S.A.		CHARLES MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
LA PLATA, MD	PHYSICIANS MEMORIAL HOSPITAL		Mechanist		Manufactory
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Charles	Waldorf	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	113 Ell Lane 20601	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Robert E. Miller		Mary Seibert			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		183-05-3095		Helen W. Miller same as 13	
18. CAUSE OF DEATH (Enter only one cause per line, and do not leave blank. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4360 RESPIRATORY ARREST					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) SEIZURE DISORDER.					
(c) CEREBROVASCULAR ACCIDENT.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
ATRIAL and VENTRICULAR ARRHYTHMIA, ABDOMINAL MASS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/4/84 19 to 5/18/84 19, that (I) (we) last saw the deceased alive on 5/18/84 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If we did not view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Sanjeeb K. Mishra		for		5/19/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
SANJEEB K. MISHRA M.D.		WALDORF, MD, 20601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		5-22-84		Huntt Crematory	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Huntt Funeral Home, Waldorf, Maryland				MAY 25 1984	
				25b. REGISTRAR'S SIGNATURE	
				Julia Davidson-Randall	

BP



BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		84 13709 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>DOLOR EUGENE MURPHY, JR.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 14 1984</b>			2b. HOUR <b>12:08 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>Cauc(white)</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 9 1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>04/09/22</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.			
10. CITY OR TOWN OF DEATH <b>LaPlata.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>State Road</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>S.H.A.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Charles</b> 13c. CITY OR TOWN <b>Bel Air</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>PO Box 75 Bel Air, Md 20611</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Dolor Eugene Murphy, Sr.</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Rice</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>					16b. SOCIAL SECURITY NO. <b>217-32-1095</b>		17. INFORMANT <b>Elizabeth C. Murphy Same as No. 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4029</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardio Vascular disease 4 months</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension in Cardiovascular disease 12 yrs.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:6.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>14 May 1984</b> to <b>14 May 1984</b> , that (I) (we) last saw the deceased alive on <b>14 May 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Arthur O. Wooddy MD</b>					DEGREE		22c. DATE SIGNED <b>14 May 84</b>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTHUR O. WOODDY MD</b>					22f. ADDRESS <b>Box 430 LA PLATA, MD. 20646</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>05/16/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>La Plata Charles Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Arehart Funeral Home, Inc., La Plata, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>MAY 17 1984</b>		25b. REGISTRAR'S SIGNATURE <b>F. Davidson-Randall</b>		



CHIEF



Archard Funeral Home, Inc., 121st St., N.Y.C.

Charles H. ... MAY 19 1942

217-35-1085 Elizabeth C. Murphy, June 28, 1912

John ... Eugene ... William ...

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13710

1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) <b>John L MYLES</b>										MONTH DAY YEAR <b>5 10 84</b>		5 <sup>00</sup> P M	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH (MONTH DAY YEAR) <b>Nov 19 1921</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b>	7. IF UNDER 1 YR. MONTHS DAYS	7. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR <b>5 10 84</b>		2d. HOUR <b>7<sup>00</sup> P M</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.							
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial HOSPital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>aluminum siding</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Constructi</b>					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Waldorf</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1719 Brightwell Ct. 20601</b>					
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>James E. Myles</b>				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Ida May Fife</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>WWII</b>		17. INFORMANT (NAME AND ADDRESS) <b>Ronald E. Myles Same as #13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4292 ASCVD</b> IMMEDIATE CAUSE (a) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY (HOUR A.M. MONTH DAY YEAR) <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>H.M. Mahan. Haft</b>				TITLE (SPECIFY) <b>M.D. Charles Co</b>				DATE SIGNED <b>11 May 84</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>H.M. Mahan. Haft</b>				ADDRESS <b>SR#1 Box 1020 La Plata Md 20646</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-15-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veterans Cemetery</b>				23d. LOCATION (CITY OR TOWN COUNTY STATE) <b>Cheltenham Md</b>					
24. FUNERAL DIRECTOR NAME <b>Robert E. Wilhelm</b>				ADDRESS <b>Suitland, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 16 1984</b>					



MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 2), should be detached for use at the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 8413711				
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROBERT BENNETT PRICE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>May 12, 1984</b>			2b. HOUR P.M. <b>5:20</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 18, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>69</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles County, MD.</b>			
10. CITY OR TOWN OF DEATH <b>White Plains</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pickeral Street Zip 20695</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Printer, Retired Newspaper</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Charles</b> 13c. CITY OR TOWN <b>White Plains</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET ADDRESS <b>Pickeral Street P.O. Box 393, La Plata, Md. 20646</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Bennett Price</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Henrietta Coleman</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 11</b>		17. INFORMANT ADDRESS <b>Margaret Price - Wife, Same as # 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2898 Agnogenic Myeloid Metaplasia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <b>Deviates Uterus</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19_____, to <b>5-12</b> , 19 <b>84</b> , that (I) (we) lost <b>5-5</b> <b>1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <b>Wm J Burke MD</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5-13-84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5/15/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waldorf, Maryland</b>			
24. FUNERAL DIRECTOR <b>Arehart Funeral Home, Inc., La Plata, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>MAY 17 1984</b> 25b. REGISTRAR'S SIGNATURE <b>Arla Davidson-Rendell</b>				

MEDICAL CERTIFICATION



May 13, 1954

White Plains, Maryland  
 210 20892  
 Printer, Retired Newspaper  
 P.O. Box 233, La Plata, Md.  
 20646

Robert Funeral Home, Inc., La Plata, Md.  
 20646



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3712	
1. DECEASED NAME (TYPE OR PRINT) <b>William R. Riley</b>						2a. DATE KNOWN OF DEATH <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> <b>5 9 1984</b>		2b. DATE OF DEATH <b>5 9 1984</b>		2c. TIME OF DEATH <b>9:00 AM</b>	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 21 01</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>82 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD <b>5 9 1984</b>		2d. TIME OF DEATH <b>9:26 AM</b>		2e. TIME OF DEATH <b>9:26 AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles County</b> MD.				
10. CITY OR TOWN OF DEATH <b>La Plata</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial</b>			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>farmer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>farming</b>		
13a. STATE <b>Md.</b>			13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Hughsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 1 Box 359 20637</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Riky</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>220-26-2571-A</b>			17. INFORMANT <b>Ruth Riley</b>			ADDRESS <b>same as #13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A.S.C.V.D.</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>H.M. Mahan. Hoff</b>			TITLE (SPECIFY) <b>Charles Co</b>			M.D. <b>Charles Co</b>			DATE SIGNED <b>5/9/84</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>H.M. Mahan. Hoff, MD</b>			ADDRESS <b>SR#1 Box 1020, La Plata, Md 20646</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>May 12, 1984</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Southern Memorial Gardens Dunkirk</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Calvert Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Rausch Funeral Home</b>						25a. DATE REC'D. BY REGISTRAR <b>MAY 16 1984</b>					
ADDRESS <b>Owings, Md.</b>						25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					



MAY 1 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 84 13713

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
MARY Leslie		ROBERTSON		MAY 17 1984		4:12P M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE	Cau.	Sept. 15, 1908		75			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland	U.S.A.			CHARLES		C & P Telephone Co.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
LA PLATA	PHYSICIANS MEMORIAL HOSPITAL		Supervisor				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Charles		Indian Head		11 Circle Avenue, 20640	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
James J. Wright		Flora Bowie					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		577-01-2563		Ethel F. Maxwell same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TRACHEO ESOPHAGEAL FISTULA</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11 HRS</u>	
1509							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>POST ESOPHAGECTOMY</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>CARCINOMA ESOPHAGUS.</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
APRIL 24, 84		CARCINOMA ESOPHAGUS					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
		19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 16, 1984</u> , to <u>MAY 17, 1984</u> , that (I) (we) lost the deceased alive on <u>MAY 16, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<i>Chinmoy Banerjee</i>						MAY 17, 84.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
CHINMOY BANERJEE, M.D.		WALDORF, MARYLAND		20601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		5-20-84		Trinity Mem. Gardens		Waldorf, Charles, Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			
Huntt Funeral Home, Maryland				MAY 21 1984			



Franklin

Can.

Jan. 1, 1900

75

U.S.N.

X

Supervisor

C. & P.  
Telephone Co.

11 Atlantic Avenue, 50040

Charles Nathan Reed

Place

Bright

James J.

577-71-2521 (L) F. Max all name as is

2-22-00 Trinity Ave. Boston, Mass., U.S.

Robert Samuel Reed, Bright, Vermont

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		2:52 AM	
FIRST MIDDLE LAST		5 10 84			
Joan N/M/N Scott					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	59 YRS.	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
South Wales	U.S.A.		Charles MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
La Plata	Physicians Memorial HOsPital		Homemaker		Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Rt.#1 Box 3 Zip: 20662		
Md. Charles Nanjemoy					
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)			
Elvet Davies		Gwendolyn Morgan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		214-58-4405		Walter S. Scott Same As #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Metastatic Carcinoma of Breast					
DUE TO, OR AS A CONSEQUENCE OF (b) Pathologic Fracture of Bone Humerus					
DUE TO, OR AS A CONSEQUENCE OF (c) Multiple mets. to Bone and Lung					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
**Fracture was seen/okayed by Dr. Mahon/Haft M.E. Chas. Co.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1981, 19, to 5/10, 1984, that (I) (we) last saw the deceased alive on 5/9, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
G.B. WATKIN				5/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
		LABLATA, Md 20646			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		5-13-84		Nanjemoy Baptist Cem. Nanjemoy Charles Md.	
24. FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Arehart Funeral Home, Inc. La Plata, Md		MAY 14 1984		John Davidson-Robert	

Burial 5-13-51 Anthony Baptist Ch. Anthony Charles M.

Archert Funeral Home, Inc. 14 First, Miami 14

Er. cause was seen by Dr. Johnson, H. L. Chas. Co.

Five

21-52-4402 Walter B. Scott

David Gwendolyn Jordan

Ms. Charles Anthony Rt. 1 Box 3

21-50-652

Home, Homenaker

Charles

Female White Nov. 8, 1924

WMA

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXPLAIN THE DELAY IN WRITING ON THE REVERSE OF THIS FORM. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 3011 PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3715			
1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) WILLIAM L. SCOTT										2c. DATE OF DEATH		2d. HOUR	
3. SEX Male 4. RACE Cau. 5. DATE OF BIRTH April 9, 1937 6. AGE (IN YEARS) 47										7. DATE OF DEATH		7d. HOUR	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas 9. CITIZEN OF WHAT COUNTRY? U.S.A.										10. DATE OF DEATH		10d. HOUR	
11. CITY OR TOWN OF DEATH LaPlata 12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Physicians Memorial Hospital										13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mech. Engineer		14. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
15. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Maryland 15b. COUNTY Charles 15c. CITY OR TOWN White Plains										16. INSIDE CITY LIMITS? YES NO		17. STREET ADDRESS Rt. #1 Box 115, 20695	
18. FATHER'S NAME (FIRST MIDDLE LAST) Harvey Scott 19. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Esther Dwinell										20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes Vietnam		21. SOCIAL SECURITY NO. 509-34-9127	
22. INFORMANT ADDRESS Gweneth A. Scott same as 13										23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
25. IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										26. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		27. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 28. AUTOPSY? YES NO	
29. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		32. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 33. LOCATION STREET CITY OR TOWN COUNTY STATE	
34. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner										35. ACTUAL SIGNATURE Margarita A. Korell, M.D.		36. TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
37. EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. 38. ADDRESS 111 Penn Street										39. DATE SIGNED 5-31-84		40. DATE REC'D. BY REGISTRAR 41. REGISTRAR'S SIGNATURE	
42. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 43. DATE 6-2-84 44. NAME OF CEMETERY OR CREMATORY St. Joseph's Cem.										45. LOCATION CITY OR TOWN COUNTY STATE Pomfret, Charles, Md.		46. FUNERAL DIRECTOR NAME ADDRESS Hunt Funeral Home, Waldorf, Maryland	

X

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1991-1992

6 June 1993

141-202-30

45-5-2

1424



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE "CHIEF" MEDICAL ALCING WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 33716	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Esther Irene Sidler										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5-10 19 84	2b. HOUR M 12:50 P. M.
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR July 27, 19 64 YRS.	6. AGE (IN YEARS) LAST BIRTHDAY 64 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-10 19 84	7d. HOUR P. M.	9. BALTIMORE CITY OR COUNTY OF DEATH Charles County, MD.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physician's Memorial Hospital				12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12d. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Hwy. 5, Box 21, 20601			
14. FATHER'S NAME FIRST MIDDLE LAST Ernest Pickeral				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Atchison							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----215-44-3714		17. INFORMANT (Spouse) ADDRESS Milton E. Sidler, Sr. Same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9550 IMMEDIATE CAUSE (a) Gunshot wound of Head (handgun) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? (head only) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY approx. HOUR A.M. MONTH DAY YEAR 10:00x 5-10 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject shot herself					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) yard of home (head only)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 7, Box 21, Waldorf, Charles County, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Dennis F. Smyth, M.D.				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 5-11-84			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-14-1984		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, Md.				
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Md.				25a. DATE REC'D. BY REGISTRAR MAY 15 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez				



10-11-1961

10-11-1961

(10-11-1961)

10-11-1961

10-11-1961

10-11-1961

10-11-1961

10-11-1961

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

8 REG. NO. 13717

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Reuth Anesie</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>05/01/84</i>			2b. HOUR HOURS MINUTES <i>10-18</i> M.				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10-20-1909</i>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <i>74</i>		7. UNDER 1 YEAR MONTHS DAYS <i>74</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>CHARLES COUNTY</i> MD.				
10. CITY OR TOWN OF DEATH <i>La Plata, Md.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Charles County Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Secretary</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>CIA US GOV'T.</i>		
13a. STATE <i>MARYLAND</i>			13b. COUNTY <i>CHARLES</i>		13c. CITY OR TOWN <i>INDIAN HEAD</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>BOX 76L CHAPMAN LANDING RD.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>BENJAMIN SNESIL</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>FANNIE LEVIN</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>216-02-5927</i>		17. INFORMANT <i>MRS. ESTHER ROSENSTEIN</i> BOX 389 <i>HIGHWAY 5 WALDORF, MD 20601</i>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Organic brain damage</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Cardiovascular disease</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i> <i>Months.</i> <i>Years.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>03/26</i> 19 <i>80</i> to <i>05/01</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>05/01</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Arthur O. Woody</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>05/01/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ARTHUR O. WOODY, MD</i>		22e. ADDRESS <i>Box 430 LA PLATA, MD. 20646</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>MAY 3, 1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>HEBREW FRIENDSHIP</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE MARYLAND</i>	
24. FUNERAL DIRECTOR NAME <i>SOL LEVINSON &amp; BROS., INC.</i>				25a. DATE REC'D. BY REGISTRAR <i>MAY 8 1984</i>			
25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>				26. ADDRESS <i>6010 REISTERSTOWN RD. BALTO., MD 21215</i>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3718

1. FOR STATE REGISTRAR										20. DATE KNOWN OF DEATH										21. HOUR OF DEATH																			
1. DECEASED NAME (TYPE OR PRINT) <b>Scott Alan Telford</b>										20. DATE KNOWN OF DEATH <b>5 26 19 84</b>										21. HOUR OF DEATH <b>11 50 P M</b>																			
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>6 22 68</b>			6. AGE (IN YEARS) <b>15</b> YRS.			IF UNDER 1 YR. MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.			22. DATE PRONOUNCED DEAD <b>5 26 19 84</b>			23. HOUR OF DEATH <b>11 50 P M</b>																		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kansas</b>					7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.																								
11. CITY OR TOWN OF DEATH <b>Waldorf</b>					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2209 Pinefield Court</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student - Secondary School</b>					12b. KIND OF BUSINESS OR INDUSTRY																			
13a. STATE <b>Maryland</b>										13b. COUNTY <b>Prince Charles</b>					13c. CITY OR TOWN <b>Waldorf</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS <b>2209 Pinefield Ct. 20601</b>														
14. FATHER'S NAME <b>George</b>										15. MOTHER'S MAIDEN NAME <b>Janie Wadsworth</b>																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>										16b. SOCIAL SECURITY NO. <b>N/A</b>										17. INFORMANT ADDRESS <b>George Telford (father) same as #13</b>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunsight wound to the head</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instantaneous</b>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11 P.M. 26 May 19 84</b>										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Russian Roulette</b>																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>										21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>2209 Pinefield Ct. Waldorf MD</b>																			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																																							
ACTUAL SIGNATURE <b>H.M. Males</b>										TITLE (SPECIFY) <b>Charles G</b> M.D.										MEDICAL EXAMINER DATE SIGNED <b>26 May 84</b>																			
EXAMINER'S NAME (TYPE OR PRINT) <b>H.M. Males</b>										ADDRESS <b>South 1 Box 1000 La Plata, MD 20646</b>																													
23a. BURIAL LOCATION, REMOVAL (SPECIFY)										23b. DATE <b>5-31-84</b>										23c. NAME OF CEMETERY OR CREMATORY <b>Maize Cemetery</b>										23d. LOCATION CITY COUNTY STATE <b>Maize, Kansas</b>									
24. FUNERAL DIRECTOR NAME <b>Ives-Pearson Funeral Home Arlington, Va.</b>																				25a. DATE REC'D. BY REGISTRAR <b>JUN 07 1984</b>										25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>									



RECEIVED  
JAN 10 1962  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

RECEIVED

JAN 10 1962

U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

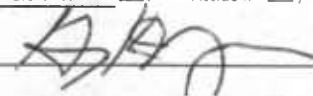
BP

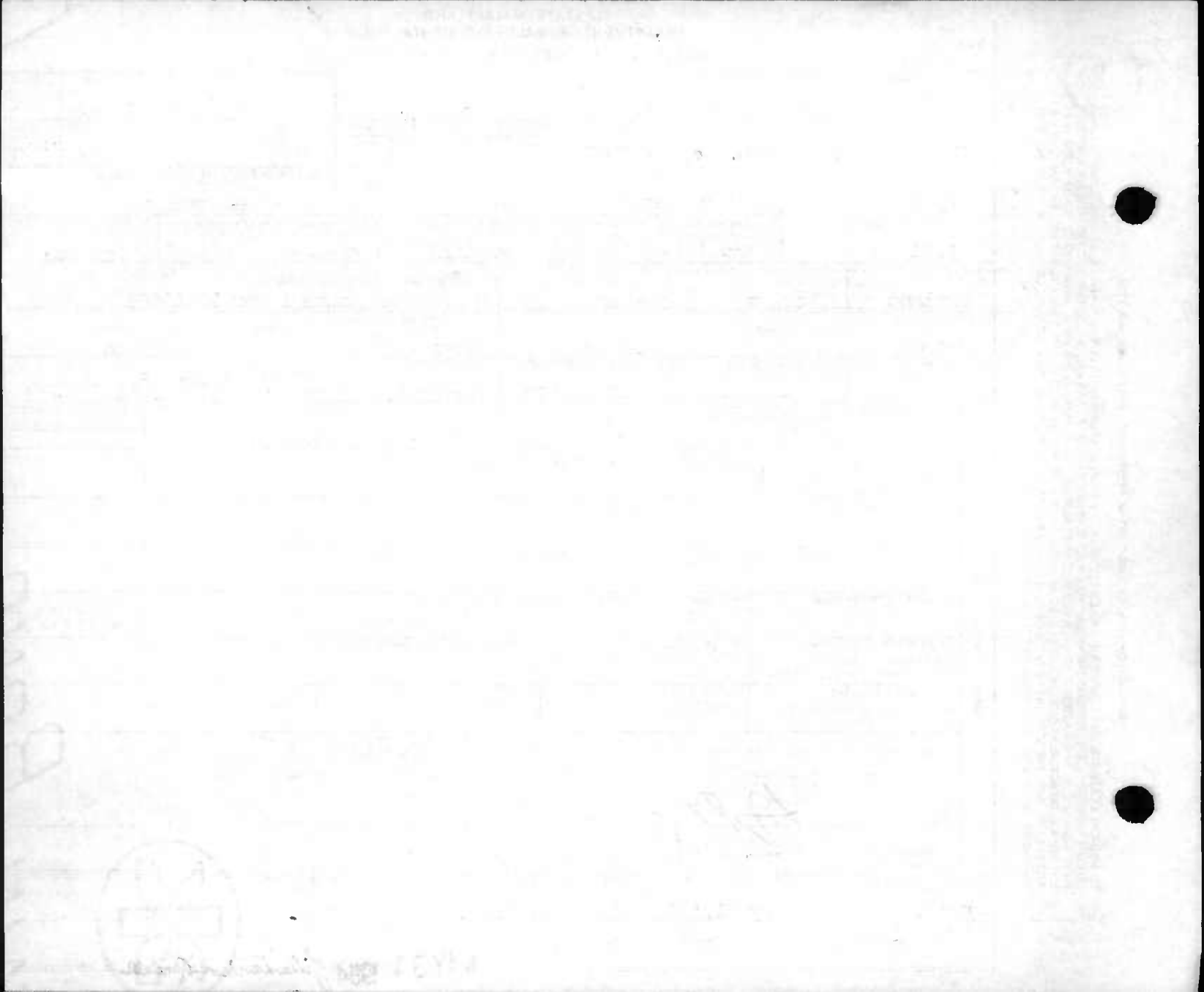
DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO. 3 7 1 9

1. DECEASED NAME (TYPE OR PRINT) George J. Thomas			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 27 1984			2b. HOUR M 5:07P M		
3. SEX MALE	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Feb. 6, 1917	6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 27 1984		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County, MD.		
10. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Private	
13a. STATE Maryland			13b. COUNTY Charles		13c. CITY OR TOWN Newburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Thomas			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Green		13e. STREET ADDRESS Route 1 Box 13 20664			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 214-12-7817B		17. INFORMANT ADDRESS Route 1 Box 45 Joseph L. Thomas Newburg, Maryland 20664				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 5/28/84		
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.			ADDRESS 111 Penn St. Balto., MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 31, '84		23c. NAME OF CEMETERY OR CREMATORY Shiloh Un. Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE Newburg Charles Md.		
24. FUNERAL DIRECTOR NAME Thornton Funeral Home			Pomomkey, Md.			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 31 1984 Julia Swickard-Randall		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 84 13720

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		6:26 PM	
Frank History Wallace		May 26, 1984			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
Male	Black	July 5, 1910	73 YRS.	Charles MD.	
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
Maryland	U.S.A.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY	
La Plata	Physicians Memorial Hospital	Self Employed		Tavern Owner	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Zip: 20646	
Md.	Charles	La Plata		Rt. #4 Box 4007	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Henry Wallace		Annie Wills			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
NO		212-14-3998		Emma H. Wallace same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>pulmonary edema</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>lung cancer</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>arteriosclerotic heart disease, chronic obstructive lung disease</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
None		Hypertension, mild		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
(IF EITHER, NOTIFY MEDICAL EXAMINER)		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHERE <input type="checkbox"/> AT WORK NOT WHERE <input checked="" type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
		n/a		n/a	
22a. I certify that (I) (this hospital) attended the deceased from 5/20/84, 1984, to 5/26/84, 1984, that (I) (we) last saw the deceased alive on 5/26/84, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Paul Pritchett MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		5/27/84	
22d. PHYSICIAN'S NAME		22e. ADDRESS			
Paul Pritchett M.D.		La Plata, Md.			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
(SPECIFY)		5-30-84		Mt. Rest Cemetery	
Burial				La Plata Charles Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Name		JUN 4 1984		John Davidson	
Arehart Funeral Home, Inc. La Plata, Md.					



Male	Black	July 2, 1925	73
Maryland	U.S.A.	x	
No. 1	Charles La Plata	x	
Henry	Wallace	Annie	
212-14-1925	Emma H. Wallace	same as 212	

*[Faint, illegible handwritten notes and markings, possibly including a signature and various scribbles.]*

Funeral Home, Inc. La Plata, Md.  
2-30-44 Rt. Post Cemetery  
La Plata, Charles, Md.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, THE MEDICAL EXAMINER SHOULD WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE MEDICAL EXAMINER'S SIGNATURE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME(5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Woodrow N/M/W Willett</b>						20. DATE KNOWN OF DEATH MONTH <b>5</b> DAY <b>11</b> YEAR <b>1984</b>			21. HOUR OF DEATH <b>6:54 A.M.</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Nov.</b> DAY <b>10</b> YEAR <b>1915</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>68</b> YRS.		IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.	
10. CITY OR TOWN OF DEATH <b>La Plata</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Apt. Complex</b>	
13a. STATE <b>Maryland</b>											
13b. CITY OR TOWN <b>Charles</b>				13c. CITY OR TOWN <b>Waldorf</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS <b>Rt#925 Box 143, 20601</b>											
14. FATHER'S NAME FIRST <b>Dominic</b> MIDDLE <b>Guy</b> LAST <b>Willett</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Virgie</b> MIDDLE <b>Irene</b> LAST <b>Pickeral</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>213-16-2019</b>				17. INFORMANT ADDRESS <b>Mary Ruth Adell same as 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASCD</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>H M Mahan H</b>				TITLE (SPECIFY) <b>Charles Co</b>				MEDICAL EXAMINER <b>SR#1 Box 1020 La Plata Md 20646</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>H M Mahan Hatt M</b>				ADDRESS <b>SR#1 Box 1020 La Plata Md 20646</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>5-14-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waldorf, Charles Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Huntt Funeral Home, Waldorf, Maryland</b> ADDRESS <b>MAY 15 1984</b>											

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